jeopardy, which means that American children's health is in jeopardy. Not only do proposals include a cut to SNAP, but also, without Congressional intervention, the ARRA benefit boost will end in November, 2013, creating a double benefit cut. SNAP is a crucial nutritional support for the health and development of America's children. Scientific evidence shows that SNAP is a wise investment in the brains and bodies of America's children, an investment that should be increased, not curtailed.

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Primary-care research to inform policy and implementation


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On a daily basis general practitioners (GPs) deal with a wide range of disorders—from benign to life threatening—and mixed populations of patients, in whom even minor illness might pose a severe health threat. The ability to handle uncertainty is, therefore, an essential part of day-to-day general practice. Much of what has been called the essence of general practice[1] can be seen as the development of effective coping strategies, achieved through the application of knowledge built up over time about the patient, understanding of risks, case reviews, continuity, leadership, and advocacy. These empirically acquired characteristics, however, have only occasionally been brought to the scientific test.

Respiratory-tract infections illustrate well the uncertainty in general practice. Infections are generally self-limiting, and explanation and advice is frequently sufficient for management. Antibiotics might occasionally be required, but prescription on a better-safe-than-sorry basis from the early days of antibiotic use has led to population resistance, the effects of which are becoming ever clearer in primary care.[2]

Concerted action is needed to maintain a range of effective antibiotics. In *The Lancet*, Paul Little and colleagues[3] present a large randomised intervention study done in 246 European GP practices. The intervention was directed at two aspects of the consultation. First, diagnostic support was offered through point-of-care C-reactive-protein (CRP) testing to help distinguish between self-limiting and more severe infections. Second, online training in communication skills was aimed at improving GPs' understanding of patients' concerns, perceived needs, and expectations, enabling GPs to provide information about the disease course, and make informed management decisions. Each intervention alone was associated with a decrease in prescribing of antibiotics compared with usual care (CRP 33% *vs* 48%, adjusted risk ratio 0·54, 95% CI 0·42–0·69; communication training 36% *vs* 45%, 0·69, 0·54–0·87). When the interventions were combined the prescribing of antibiotics was

reduced further (CRP risk ratio 0·53, 95% CI 0·36–0·74; enhanced communication 0·68, 0·50–0·89; combined 0·38 0·25–0·55). These effects of the intervention are in themselves welcome, and I compliment Little and colleagues for undertaking a complex study in real-life general-practice conditions and in multiple countries. The interventions used seem inexpensive, which will make it interesting to find out whether the effects are retained in the long term; the prescribing of antibiotics is well established in routine practice, and established routines are frequently the hardest to change.

A related point of interest is how far the antibiotic prescribing rates can be lowered without leading to undertreatment of infectious disease. Whether reduced antibiotic prescribing will remain best, or whether there will be a cutoff point at which reduced prescribing becomes harmful, and how that might affect population resistance to first-line antibiotics, remain unclear. Prescribing of antibiotics in primary care has been a major driver of antibiotic resistance and to some degree is the societal price paid for overemphasis of these drugs' benefits. Research and monitoring of efficacy and risks at the time of introduction could have forestalled this effect.

As well as indicating the need to do better with implementation of treatment in the future, the study by Little and colleagues[3] presents ways in which research can help to improve application of health policy: the GPs who received both training interventions best applied the policy of restrained use of antibiotics. The diagnostic tool relates to the specific clinical context of infections and antibiotic prescription, whereas the communication intervention was a generic tool that supported the essence of general practice.[1] The finding that the generic approach improved the outcome achieved with the diagnostic approach alone provides much-needed evidence that the nature of primary care needs to be considered. Combinations of different types of intervention might have effects well beyond reductions in antibiotic prescribing and those effects need to be understood.

Implementation and policy setting are important activities in the development of health care. In general practice, their effects are frequently determined by how successfully they can build on the generic nature of primary care. The report by Little and colleagues shows encouraging indications of how clinical research can inform health policy and implementation.

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Household tuberculosis interventions—how confident are we?

Of the nearly 9 million new cases of tuberculosis estimated to occur every year, a third are either not diagnosed or not treated. Existing approaches to case detection largely rely on patients with symptoms seeking care at health facilities. Worldwide in 2011, tuberculosis killed 1·1 million people without HIV and 0·43 million people with HIV co-infection.[1] An autopsy study of 85 eligible adults who died at home in South Africa showed that 34% had evidence of previously undiagnosed tuberculosis.[2] Therefore, active expansion of tuberculosis case-finding beyond health facilities to identify individuals with the disorder, treat them, and prevent death makes sense. At the population level, the effect of such an approach on reduction of transmission by early detection is also crucial but has never been assessed.

In *The Lancet*, Helen Ayles and colleagues[3] present the results of the Zambia, South Africa Tuberculosis and AIDS Reduction (ZAMSTAR) study, which measured the epidemiological effects of a community-level enhanced tuberculosis case-finding (ECF) intervention and a household-level tuberculosis–HIV intervention. 24 communities were randomly allocated to one of four trial groups (six communities per group): group 1, strengthened tuberculosis–HIV programme at

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